ARC 1058C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4 and 2013 Iowa Acts, Senate File 446, section 29, the Department of Human Services amends Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

These amendments change the payment methodology for the home health services program to the Medicare low utilization payment amount (LUPA) methodology, with state geographic wage adjustments. The Department will update the rates every two years. The rates for the private duty nursing and personal cares program will be based on interim rates subject to cost settlement and subject to a limit calculated by the Department and approved by the Centers for Medicare and Medicaid Services (CMS).

Payments to Medicaid home health services providers and private duty nursing and personal cares providers will be impacted for services provided to Medicaid members. Home health services will be reimbursed according to the LUPA visit schedule of reimbursement determined by Medicare. These amendments will not require any additional costing information. Private duty nursing and the personal cares program will require a change to the rate for the private duty nursing service. The private duty nursing service will change to a 15-minute unit. Personal cares service shall remain at an hourly rate. The interim rates will be cost-settled up to a cap established by the Department.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0863C** on July 24, 2013. The amendments were also Adopted and Filed Emergency and published as **ARC 0864C** on the same date and became effective July 1, 2013.

The Department received no public comments on these amendments. However, in the course of a departmental review of these amendments, the initial percentage determined for actual and allowable cost (110 percent) for private duty nursing and personal cares for persons aged 20 or under was found to be incorrect. The percentage rate has been corrected to 133 percent. This change is found in numbered paragraph "2" of Item 1.

In addition, pursuant to amendments to subrule 79.1(2) adopted in **ARC 0994C** and published in the September 4, 2013, Iowa Administrative Bulletin, the following sentence was added in numbered paragraph "1" of the "Home health agencies" provider category: "For members residing in a nursing facility, see 441—paragraph 81.6(11)'r.'"

As a result of these changes and in order to accurately convey the result of the amendments, in Item 1, the provider category "Home health agencies" is rescinded and a new entry for the category is adopted, which incorporates amendments adopted in **ARC 0994C** and incorporates the change from 110 percent to 133 percent.

The amendments were also modified to reflect a shift in language from personal care services to the personal cares program in order to clarify the difference between personal cares provided through state plan Home Health Services and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In addition, the amendments were modified to reflect a requirement from Medicaid to use a billing unit size of 15 minutes for specified services. These changes are reflected throughout Item 3.

The Council on Human Services adopted these amendments on September 11, 2013.

These amendments do not provide for waiver in specified situations because requests for waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no specific impact on private sector jobs has been found. These amendments will allow more agencies the ability to continue to provide services rather than discontinue being providers of the home health services and private duty nursing and personal cares programs. These amendments should maintain current employment in the state.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective November 6, 2013, at which time the Adopted and Filed Emergency amendments are hereby rescinded.

The following amendments are adopted.

ITEM 1. Amend subrule **79.1(2)** by rescinding provider category "Home health agencies" and adopting the following **new** provider category in lieu thereof:

Provider category	Basis of reimbursement	Upper limit
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Effective 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.

ITEM 2. Adopt the following **new** subrule 79.1(26):

79.1(26) *Home health services.*

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

ITEM 3. Adopt the following **new** subrule 79.1(27):

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. Rate determination based on cost reports. Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. Financial and statistical report submission and reporting requirements.

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension .xls or .xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be e-mailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27)*"b"*(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after

the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27)*"b."*

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27)*"a"* shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/2/13.